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Board of Vocational Nursing and Psychiatric Technicians

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BEFORE THE
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ERICH C. UNDERHILL** **3639 Midway Drive, #B351** **San Diego, CA 92110** Psychiatric Technician License No. PT 30256 Respondent.	Case No. PT 2008-3097 **ACCUSATION**

Complainant alleges:

PARTIES

1. Teresa Bello-Jones, J.D., M.S.N., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Vocational Nursing and Psychiatric Technicians, Department of Consumer Affairs.

2. On or about October 6, 1998, the Board of Vocational Nursing and Psychiatric Technicians issued Psychiatric Technician License Number PT 30256 to Erich C. Underhill (Respondent). The license was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2012.

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JURISDICTION

3. This Accusation is brought before the Board of Vocational Nursing and Psychiatric Technicians (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 118(b) of the Code states:

> The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.

5. Section 4520 of the Code states:

> Every licensed psychiatric technician under this chapter may be disciplined as provided in this article. The disciplinary proceedings shall be conducted by the board in accordance with Chapter 5 (commencing with Setion 11500) of Part 1 of Divisiion 3 of Title 2 of the Government Code.

STATUTORY PROVISIONS

6. Section 4521 of the Code states, in pertinent part:

The Board may suspend or revoke a license issued under this chapter for any of the following reasons:

> (a) Unprofessional conduct, which includes but is not limited to any of the following:
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> . . . .
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> (4) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drugs as defined in Article 8 (commencing with section 4210) of Chapter 9 of Division 2.
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> . . . .
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> (8) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in paragraph (4).

7. Section 11173 (a) of the Health and Safety Code provides, in pertinent part, that (a) no person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, by fraud, deceit, misrepresentation, or subterfuge.

REGULATIONS

8. California Code of Regulations, title 16, (Regulations) section 2576.6, states:

> (a) The licensed psychiatric technician shall safeguard patients'/clients' health and safety by actions that include but are not limited to the following:
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> . . . .
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> (2) Documenting patient/client care in accordance with standards of the profession; and
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> . . . .
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> (c) A violation of this section constitutes unprofessional conduct for purposes of initiating disciplinary action.

9. Section 2577 of the Regulations states:

> As set forth in Section 4521 of the code, gross negligence is deemed unprofessional conduct and is grounds for disciplinary action. As used in Section 4521 "gross negligence" means a substantial departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent licensed psychiatric technician, and which has or could have resulted in harm to the consumer. An exercise of so slight a degree of care as to justify the belief that there was a conscious disregard or indifference for the health, safety, or welfare of the consumer shall be considered a substantial departure from the above standard of care.

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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FACTS

11. Respondent was employed as a psychiatric technician by the State of California Department of Corrections, assigned to the R. J. Donovan Correctional Facility (RJD) from August 18, 2008 until his termination from employment on July 30, 2009.

12. On or about and between December of 2008 and January of 2009, Respondent was assigned to work the Administrative Segregation Unit 6 (ASU 6) pill line third watch from 1400 hours to 2200 hours. Respondent's primary responsibilities were to administer medications to inmates as ordered by the physician and to generate daily summaries every Monday for the inmates in the mental health program for the entire week.

13. On or about January 5 and 6, 2009, while working in the ASU 6 pill line during third watch, Respondent failed to properly complete the daily summaries for the inmates in the mental health program. The daily summaries for both days were found to be identical for all of the mental health inmates/patients. Respondent admitted to his supervisor, RR, that he had photocopied one completed signed summary and used the copies for all of the inmates/patients in the mental health program in ASU 6.

14. On or about January 11, 2009, Respondent failed to complete the daily summaries for ASU 7.

15. On or about January 13, 2009, Respondent's supervisor, RR, audited the daily summaries and noticed that the summaries for Mondays and Tuesdays were identical for all of the mental health inmates/patients in ASU 6 on the following dates: December 8, 2009, December 9, 2009, December 15, 2009, December 16, 2009, December 29, 2009, December 30, 2009, and January 19, 2009, thus charting in advance. Respondent's pre-charting involved creating a single Interdisciplinary Progress Note pre-dated with the days he worked and his signature, and making copies of same for the number of inmates in the ASU and placing these in the ASU binder.

16. On or about January 16, 2009, RR questioned Respondent about her findings and Respondent admitted to pre-charting by completing and photocopying one signed summary and using the photocopies for all of the inmate/patients in the mental health program in RJD's ASU 6.

Respondent admitted to the pre-charting and claimed he was unaware that it was an unacceptable practice.

17. On or about January 13, 2009, while working RJD's ASU 6 pill line during third watch (1400 through 2200 hours), Respondent failed to administer court-ordered medication to Inmate B in cell #206. Inmate B was scheduled to receive Zydis 10mg on January 13, 2009, during the PM pill pass. Respondent failed to initial the Medication Administration Record (MAR) as having administered the Zydis 10mg. on January 13, 2009, during the PM pill pass, and an audit on January 14, 2009, confirmed that the Zydis 10mg had not been given. Part of Respondent's duties as a pill line nurse were to complete a MAR audit prior to the end of his shift to document no shows and refusals, and Respondent failed to complete the audit at the end of his shift. By not administering the court ordered medication, the inmate/patient was denied access to care and could have had adverse psychological effects.

18. On or about February 9, 2009, at 1800 hours, Respondent administered Phenobarbital to the wrong inmate/patient. Respondent charted that he gave the wrong inmate/patient the medication twice on the same date and time.

19. On or about February 10, 2009, while working in the RJD's Building 2 pill line during third watch (1400 through 2200 hours), Respondent failed to give the PM medications, scheduled to be given to inmate/patients at 2000, to approximately half of the inmate/patients in Building 2. Respondent failed to notify his supervisor or the doctor that he was unable to pass the medications. Respondent documented on the MAR that the medication was not available, which was not the case. After the end of Respondent's shift, another staff member was directed to complete the medication pass. Respondent jeopardized the safety of the institution staff by not passing the medication to the inmate/patients in a timely manner, which could have resulted in inmate/patients acting out toward staff, suicidal tendencies on the part of the inmate/patients, and deprivation of health care to Respondent's assigned patients/inmates.

20. On or about February 10, 2009, Respondent administered the wrong medication to an inmate/patient. Respondent signed out the patient-specific controlled medication and wrote that

Respondent gave it to inmate/patient H, when in fact Respondent gave it to inmate/patient B, thereby giving the wrong medication to inmate/patient B.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct- False and/or Grossly Incorrect Entries in Hospital Records)

21. Respondent is subject to disciplinary action pursuant to Code section 4521(a)(8), on the grounds of unprofessional conduct, in that on or about and between December of 2008 and February of 2009, Respondent pre-charted and reproduced patient daily summaries, failed to complete daily summaries by the end of his shift, and made inaccurate entries in MAR's indicating that the reason for not administering medications to inmate/patients was because the medications were not available, when in fact the medications were available. This is more fully detailed at paragraphs 11-20, which are incorporated here by reference.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

22. Respondent is subject to disciplinary action pursuant to Code section 4521(a), on the grounds of unprofessional conduct for gross negligence, as defined by Regulation section 2577, as follows:

a. On or about January 13, 2009, Respondent failed to administer court-ordered medication to Inmate B.

b. On or about February 9, 2009, Respondent failed to administer the post meridiam medications to inmate/patients.

c. On or about February 9, 2009, at approximately 1800 hours, Respondent charted that he administered the drug Phenobarbital twice to the wrong inmate/patient.

d. On or about February 10, 2009, Respondent administered the wrong medication to the wrong patient.

This is more fully detailed at paragraphs 11-20, which are incorporated here by reference.

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THIRD CAUSE FOR DISCIPLINE

(Failure to Document Client Care)

23. Respondent is subject to disciplinary action pursuant to Code section 4521(a) on the grounds of unprofessional conduct as defined by Regulation section 2576.6(a)(2), in that Respondent failed to document patient/client care in accordance with standards of the profession, as is more fully detailed at paragraphs 11-20, which are incorporated here by reference.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Vocational Nursing and Psychiatric Technicians issue a decision:

1. Revoking or suspending Psychiatric Technician License Number PT 30256, issued to Respondent Erich C. Underhill;

2. Ordering Erich C. Underhill to pay the Board of Vocational Nursing and Psychiatric Technicians the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: January 11, 2011

TERESA BELLO-JONES, J.D., M.S.N., R.N.
Executive Officer
Board of Vocational Nursing and Psychiatric Technicians
Department of Consumer Affairs
State of California
Complainant

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